DEPARTMENT OF BENEFIT PAYMENTS
744 P Street, Sacramento, CA 95814

June 4, 1975

ALL-COUNTY LETTER NO. 75-112

TO: ALL COUNTY WELFARE DIRECTORS

OBSOLETE

Superseded by ACL #77-15

Issued 3-17-77

SUBJECT: REVISED FORMS WR 2, WR 2.2 AND WR 3

REFERENCE:

Attached are revised forms WR 2 (Statement of Facts Supporting Eligibility for Assistance), WR 2.2 (Stepfather Questionnaire-Declaration), and WR 3 (Eligibility Determination Summary - AFDC). These advance copies are being provided to allow sufficient lead time to counties for training purposes and to facilitate planning for implementation. You will be notified in the normal manner (via Notice of Forms Change) when the new forms are available from Central Stores, which should be in July.

Several major improvements to the WR 2 have been made and are worthy of specific mention. First, and perhaps foremost, the AFDC program content pages have been reduced from eleven to seven. This was accomplished by consolidating certain sections and by the elimination of data items which are either duplicated on other forms or which are now considered to be of marginal usefulness. This reduction in size alone will facilitate the eligibility determination process.

Another significant improvement is the addition of two pages of food stamp related data at the end of the WR 2. This eliminates the need for completion of the WR 2A as well as the WR 2 for AFDC/Food Stamp applicants. AFDC applicants who choose not to apply for food stamps will not have to complete these pages.

The instruction page of the WR 2 has been modified to implement EAS 20-006.21 which requires that both applicant and eligibility worker certify that the applicant is aware of possible criminal penalties for misrepresentation or concealment of facts. Two of these instruction pages are attached to each WR 2. After both the applicant and EW have signed the first instruction page, it must be removed to become part of the permanent case record. The other instruction page should be retained by the applicant as is currently done.

Page one of the new WR 2 contains two boxes in the "county use only" space which are designed to record recipient ethnic origin (E.O. CODE) and primary language capability (P.L. ITEM). A detailed explanation of the use of these codes will be sent to you soon in a separate All-County Letter.

The revised WR 2 reflects the new property regulations which became effective in May (Item 17). The applicant can now list most personal property items in one section regardless of the category. After determining the current value of the

property item the EW can refer to the categorical examples in the section heading. This will help identify the proper column within the "county use only" space for the eligibility worker to list the value of the items.

The Social Services section of the WR 2 (Item 22) has been expanded to more clearly convey the availability of health screening and family planning services. (An All-County Letter is being prepared to further explain the requirements of the Child Health Disability Prevention Program).

The major change to the WR 3 is the addition of the case summary information formerly included at the bottom of the first page of the WR 2. This section was moved to provide all case summary information on one form. Primarily because of this change, only a revised WR 3 should be used with a revised WR 2.

The primary change to Form WR 2.2 is the addition of Items 3 and 4 soliciting information about income tax exemptions claimed by the stepfather.

Spanish translations of the revised WR 2 and WR 2.2 are being developed and will be available soon.

The revised WR forms are products of the state/county task force which produced the revised WR 7 (see ACL #75-22). Input for the forms was solicited from all counties (via ACL #74-120), the CWDA and various community organizations. The Department is particularly appreciative of the responsiveness and cooperation demonstrated by the various members of the task force and extends thanks to each of them.

Any questions or concerns about the forms should be addressed to your AFDC Management Consultant at (916) 445-4458.

Sincerely,

William Kertz for

DENNIS O. FLATT
Deputy Director

Attachment

cc: CWDA

IMPORTANT INSTRUCTIONS TO APPLICANTS AND RECIPIENTS FOR COMPLETING THE STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR ASSISTANCE (FORM WR 2)

Complete each numbered/lettered box — you cannot be granted aid until all questions have been answered.

If you need help filling out this form, you can have a friend or relative help you; if you have a problem with a question, circle the question number and go on to answer the next question. After you complete this form, ask your eligibility worker for help on those questions which you circled.

Use receipts and records to help you answer questions and be prepared to show them to support your answers. Use estimates only if you do not have and cannot get records or receipts. Please circle all estimates.

Questions beginning with the statement "I/We" refer to the natural, adoptive, married, or unmarried parent or needy caretaker relative, and all minor children for whom you are applying for aid.

If you need more space, attach a sheet of paper, note the question and item numbers and give the information asked for.

STATEMENT OF RESPONSIBILITIES OF APPLICANTS AND RECIPIENTS

IF YOU ARE GRANTED AID, YOU MUST FILL OUT A MONTHLY ELIGIBILITY REPORT (FORM WR 7). IN ADDITION TO THIS MONTHLY REPORT, YOU MUST IMMEDIATELY REPORT THE FOLLOWING CHANGES TO YOUR ELIGIBILITY WORKER:

1. Report if you move or change your mailing address.

2. Report if **anyone** in your home:

   - gets married or becomes pregnant
   - is no longer incapacitated
   - returns to or drops out of school
   - attends college less than full time
   - starts or stops working on a training program
   - has an increase or decrease in income
   - moves in or out of your home
   - visits out of the state or county longer than 30 days
   - received money or property from any source such as: income tax refunds, retirement contribution refunds, insurance inheritances, gifts, awards, benefits, etc.
   - receives, transfers or sells any item of real or personal property, such as a car, T.V., refrigerator, house, insurance, etc.

IF YOU HAVE ANY DOUBT WHETHER YOU ARE REQUIRED TO REPORT A PARTICULAR CHANGE, YOU SHOULD CONTACT YOUR ELIGIBILITY WORKER IMMEDIATELY TO DETERMINE WHETHER THE CHANGE MUST BE REPORTED.

You will be notified, in writing, of the welfare department's decision on your application. If your application is denied, the reasons will be given. If you are dissatisfied with the action, or lack of action by the county welfare department, or feel you have been discriminated against in any way, you have the right to request a fair hearing and a decision by the Director of the Department of Benefit Payments. Your request must be received by the Department of Benefit Payments within 90 days of the postmarked date of the notice of action with which you are dissatisfied. You are entitled to be represented by a person of your own choosing, including legal counsel. A request for a hearing must be submitted in writing to **OFFICE OF THE CHIEF REFEREE, DEPARTMENT OF BENEFIT PAYMENTS, 744 P STREET, SACRAMENTO, CALIFORNIA 95814.**

I CERTIFY THAT I HAVE INFORMED THE APPLICANT OF THE POSSIBILITY OF CRIMINAL PENALTIES FOR MISREPRESENTATION OR CONCEALMENT OF FACTS WHICH DETERMINE HIS/HER ELIGIBILITY.

Eligibility Worker's Signature	Eligibility Worker's Number	Date

I CERTIFY THAT I AM AWARE OF THE POSSIBILITY OF CRIMINAL PENALTIES FOR MISREPRESENTATION OR CONCEALMENT OF FACTS WHICH DETERMINE MY ELIGIBILITY.

Applicant's Signature	Date

IMPORTANT INSTRUCTIONS TO APPLICANTS AND RECIPIENTS FOR COMPLETING THE STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR ASSISTANCE (FORM WR 2)

Complete each numbered/lettered box — you cannot be granted aid until all questions have been answered.

If you need help filling out this form, you can have a friend or relative help you; if you have a problem with a question, circle the question number and go on to answer the next question. After you complete this form, ask your eligibility worker for help on those questions which you circled.

Use receipts and records to help you answer questions and be prepared to show them to support your answers. Use estimates only if you do not have and cannot get records or receipts. Please circle all estimates.

Questions beginning with the statement "I/We" refer to the natural, adoptive, married, or unmarried parent or needy caretaker relative, and all minor children for whom you are applying for aid.

If you need more space, attach a sheet of paper, note the question and item numbers and give the information asked for.

STATEMENT OF RESPONSIBILITIES OF APPLICANTS AND RECIPIENTS

IF YOU ARE GRANTED AID, YOU MUST FILL OUT A MONTHLY ELIGIBILITY REPORT (FORM WR 7). IN ADDITION TO THIS MONTHLY REPORT, YOU MUST IMMEDIATELY REPORT THE FOLLOWING CHANGES TO YOUR ELIGIBILITY WORKER:

1. Report if you move or change your mailing address.

2. Report if **anyone** in your home:

   - gets married or becomes pregnant
   - returns to or drops out of school
   - starts or stops working on a training program
   - moves in or out of your home
   - is no longer incapacitated
   - attends college less than full time
   - has an increase or decrease in income
   - visits out of the state or county longer than 30 days
   - received money or property from any source such as: income tax refunds, retirement contribution refunds, insurance inheritances, gifts, awards, benefits, etc.
   - receives, transfers or sells any item of real or personal property, such as a car, T.V., refrigerator, house, insurance, etc.

IF YOU HAVE ANY DOUBT WHETHER YOU ARE REQUIRED TO REPORT A PARTICULAR CHANGE, YOU SHOULD CONTACT YOUR ELIGIBILITY WORKER IMMEDIATELY TO DETERMINE WHETHER THE CHANGE MUST BE REPORTED.

You will be notified, in writing, of the welfare department's decision on your application. If your application is denied, the reasons will be given. If you are dissatisfied with the action, or lack of action by the county welfare department, or feel you have been discriminated against in any way, you have the right to request a fair hearing and a decision by the Director of the Department of Benefit Payments. Your request must be received by the Department of Benefit Payments within 90 days of the postmarked date of the notice of action with which you are dissatisfied. You are entitled to be represented by a person of your own choosing, including legal counsel. A request for a hearing must be submitted in writing to **OFFICE OF THE CHIEF REFEREE, DEPARTMENT OF BENEFIT PAYMENTS, 744 P STREET, SACRAMENTO, CALIFORNIA 95814.**

I CERTIFY THAT I HAVE INFORMED THE APPLICANT OF THE POSSIBILITY OF CRIMINAL PENALTIES FOR MISREPRESENTATION OR CONCEALMENT OF FACTS WHICH DETERMINE HIS/HER ELIGIBILITY.

Eligibility Worker's Signature	Eligibility Worker's Number	Date

I CERTIFY THAT I AM AWARE OF THE POSSIBILITY OF CRIMINAL PENALTIES FOR MISREPRESENTATION OR CONCEALMENT OF FACTS WHICH DETERMINE MY ELIGIBILITY.

Applicant's Signature	Date

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENC

DEPARTMENT OF BENEFIT PAYMENTS

STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR ASSISTANCE

REQUIRED FORM – NO SUBSTITUTE PERMITTED

Please print all required information in ink.

(1) APPLICANT'S NAME (LAST, FIRST, MIDDLE INITIAL) | MAIDEN NAME | TELEPHONE NUMBER

MAILING ADDRESS (ADDRESS TO WHICH THE AID PAYMENT IS TO BE MAILED – NUMBER, STREET, CITY, STATE, ZIP CODE)

HOME ADDRESS (IF DIFFERENT THAN MAILING ADDRESS), IF YOU DO NOT HAVE A HOUSE NUMBER ON A CITY STREET, GIVE DIRECTIONS TO YOUR HOUSE AND ATTACH A MAP.

(2) **LIST ALL PERSONS FOR WHOM YOU ARE REQUESTING AID.**
Include any parent(s), unmarried children under 21 or unborn, and needy caretaker relatives.

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	BIRTH DATE Mo/Day/Yr	BIRTH PLACE City/State	SEX M/F	*COMPLETE FOR CHILDREN ONLY* PARENT'S NAME *(MO – Mother) (FA – Father)* (Last, First, Middle Initial)	AID NEEDED DUE TO PARENT'S (✓) DEATH	INCAPACITY	UNEMPLOYMENT	ABSENCE
MAN'S	– –	/ /							
WOMAN'S	– –	/ /							
UNMARRIED CHILDREN	– –	/ /			MO				
					FA				
	– –	/ /			MO				
					FA				
	– –	/ /			MO				
					FA				
	– –	/ /			MO				
					FA				
	– –	/ /			MO				
					FA				
	– –	/ /			MO				
					FA				
	– –	/ /			MO				
					FA				
	– –	/ /			MO				
					FA				

(3) **LIST ALL UNMARRIED CHILDREN NOT LIVING IN YOUR HOME FOR WHOM YOU ARE REQUESTING AID.**
(Explain below giving name, address and reason for living outside the home.)

(4) **LIST ALL OTHER PERSONS (friends, relatives, nonneedy caretaker) LIVING IN YOUR HOME.**

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	BIRTH DATE Mo/Day/Yr	BIRTH PLACE City/State	SEX M/F	RELATIONSHIP TO CHILDREN	DOES THIS PERSON HAVE INCOME?
	– –	/ /				☐ YES ☐ NO
	– –	/ /				☐ YES ☐ NO
	– –	/ /				☐ YES ☐ NO
	– –	/ /				☐ YES ☐ NO

COUNTY USE ONLY

Return this form to _____

E.O. CODE

Wh	Sp	Bl	AA	AI	O	F
1	2	3	4	5	6	7

P.L. ITEM

Sp	Ch	J	K	F	O
1	2	3	4	5	6

RESIDENCE MARITAL STATUS INCOME POTENTIAL

(5) **I/WE PRESENTLY LIVE IN CALIFORNIA AND INTEND TO CONTINUE LIVING HERE.** ☐ Yes ☐ No

If No, list the names of those persons who do not intend to continue living in California and explain.

NAME	EXPLANATION

(6) **I/WE ARE CITIZENS OF THE U.S.** ☐ Yes ☐ No

If No, list names of all noncitizens for whom you are applying.

LAST NAME	FIRST NAME	MIDDLE INITIAL	LAST NAME	FIRST NAME	MIDDLE INITIAL

(7) **PRESENT LEGAL MARITAL STATUS OF THE CHILD'S PARENT LIVING IN THE HOME:** ***(Check one)*** ☐ Married ☐ Never Married ☐ Commonlaw Marriage ☐ Separated (legal) ☐ Separated (informal) ☐ Divorced ☐ Widowed

If your spouse does not live with you, indicate reason (employment away from home, military, jail, etc.)

(8) **I/WE HAVE PRIVATE MEDICAL/HEALTH INSURANCE or have health insurance benefits through a present or past employer, union or employee group.** If Yes, complete the following: ☐ Yes ☐ No

TYPE OF POLICY (Check ✓)	POLICY NUMBER	NAME OF INSURANCE COMPANY	PERSONS COVERED (Name)	MONTHLY PREMIUM	PAID BY (Name)
☐ INDIVIDUAL POLICY ☐ GROUP POLICY Name of Groups				$	
☐ INDIVIDUAL POLICY ☐ GROUP POLICY Name of Groups				$	

(9) **I/WE HAD MEDICAL EXPENSES IN ANY OF THE 3 MONTHS PRIOR TO THE MONTH OF THIS APPLICATION.** ☐ Yes ☐ No

Was this medical service due to an accident for which medical costs will be paid by someone else? If you answered Yes to either of the above, complete the following. ☐ Yes ☐ No

NAME OF PATIENT	DATE OF TREATMENT	COST OF TREATMENT	COSTS PAID BY NAME (Individual/Insurance Company)
		$	
		$	

(10) **I/WE AM A VETERAN OR THE SPOUSE, PARENT OR CHILD OF A VETERAN.** ☐ Yes ☐ No

(11) **I/WE HAVE RECEIVED OR APPLIED FOR PUBLIC ASSISTANCE IN THE PAST.** ☐ Yes ☐ No

If Yes, complete the following: Public Assistance includes AFDC (Aid to Families with Dependent Children), Food Stamps, Medicare/Medi-Cal, SSI/SSP (Supplemental Security Income/State Supplemental Program), or General Relief. *Include applications that have been denied.*

PUBLIC ASSISTANCE	DATE APPLIED	DATE RECEIVED OR DATE EXPECTED	WHERE RECEIVED STATE/COUNTY

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☐ WR 6 ☐ WR 6
☐ WR 6 ☐ WR 6
☐ WR 6 ☐ WR 6
☐ WR 5

(12) A.
I/WE RECEIVE THE FOLLOWING GROSS (TOTAL) INCOME MONTHLY. Complete each item.

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SOURCE OF INCOME	If None Check (✓)	Have Applied For Check (✓)	1 APPLICANT Monthly Amount	2 SPOUSE Monthly Amount	3 OTHER HOUSEHOLD MEMBER (Name) Monthly Amount
1. Earnings before deductions for members 14 and over (wages, salary, tips, commission, bonuses)			$	$	$
2. Public Assistance or SSI/SSP			$	$	$
3. Unemployment Insurance.			$	$	$
4. Disability Insurance			$	$	$
5. Worker's Compensation			$	$	$
6. Veteran's Benefits			$	$	$
7. Military Allotments			$	$	$
8. GI Bill Benefits			$	$	$
9. Social Security Payments/ Railroad Retirement			$ CLAIM NUMBER	$ CLAIM NUMBER	$ CLAIM NUMBER
10. Retirement and/or Pensions			$	$	$
11. Child Support and/or Alimony			$	$	$
12. Contributions (parents, nonneedy relative caretakers, children, others)			$	$	$
13. Rental (land, buildings, vehicles) *(Attach a sheet of paper listing expenses)*			$	$	$
14. Payment from Boarder (including relative)			$	$	$
15. Self-Employment/Farm Income (attach a sheet of paper listing expenses)			$	$	$
16. Training Allowances			$	$	$
17. Strike Benefits			$	$	$
18. Student Scholarships, Grants, Loans.			$	$	$
19. Prizes, Cash Gifts and Awards			$	$	$
20. Income for Care of a Foster Child.			$	$	$
21. Other (specify):			$	$	$
22. Noncash Income					
Free Rent or Free Housing			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Free Food			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Free Utilities			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Free Clothing			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Expenses $ _____

Expenses $ _____

B. I/WE RECEIVE OR WILL RECEIVE INCOME LESS OFTEN THAN MONTHLY. ☐ **Yes** ☐ **No**
If Yes, complete the following (include interest, dividends, royalties, pending legal settlements, tax refunds, etc.):

NAME	SOURCE OF INCOME	RECEIVED HOW OFTEN (Quarterly, annually, etc.)	AMOUNT
			$
			$
			$

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C. I/WE PAY THE FOLLOWING CHILD SUPPORT OR ALIMONY UNDER COURT ORDER MONTHLY:

Amount	$	State of Order	
Date of Order		Paid to Whom	
County of Order		Address	

(13) COMPLETE THE FOLLOWING FOR FAMILY MEMBERS WHO ARE 16 OR OVER AND LIVING IN THE HOME:

A. I/We (16 or over) **are presently working.** If Yes, complete the following: ☐ Yes ☐ No

		1	2	3
1. Working Member's Name				
2. Name of Employer				
3. Address of Employer				
4. Days of Work Per Month		Days	Days	Days
5. Hours of Work	Per Week	Hours	Hours	Hours
	Per Month	Hours	Hours	Hours
6. When Paid	How Often *(every other week, twice a month, etc.)*			
	Day of Week			
7. Gross (total) Monthly Earnings (before deductions)	Cash	$	$	$
	Noncash	$	$	$
B. MONTHLY DEDUCTIONS AND EXPENSES				
1. Number of Dependents Claimed for tax withholding purposes				
2. Required Payroll Deductions (Income tax, Social Security, Disability Ins.)		$	$	$
3. Required Retirement Contribution		$	$	$
4. Actual cost to worker of tools, materials, licenses, and union dues required by work		$	$	$
5. Cost to worker for additional food, clothing and personal items required solely by work		$	$	$
6. Cost of Child Care		$	$	$

NAME AND ADDRESS of Baby Sitter or Child Care Center

C. TRANSPORTATION TO AND FROM WORK		Check (✓)	Days	Check (✓)	Days	Check (✓)	Days
1. Method *(Check items that apply and give the number of days per month for each item checked.)*	Use your own car.	☐		☐		☐	
	Drive car alone	☐		☐		☐	
	Car pool	☐		☐		☐	
	Public (bus, train)	☐		☐		☐	
	Other (specify)						
2. Daily Miles (round trip work and child care)			Miles		Miles		Miles
3. Daily Cost (round trip work and child care)		$		$		$	

D I/WE (16 and over) ARE PRESENTLY ATTENDING SCHOOL OR A TRAINING PROGRAM. ☐ Yes ☐ No
If Yes, complete the following:

NAME	AGE	NAME OF SCHOOL OR TRAINING PROGRAM	CITY	NO. OF SCHOOL UNITS/HOURS

E. **I/We worked in the last 30 days but are not currently working.** ☐ Yes ☐ No
I/We are on strike or a leave of absence from a job. ☐ Yes ☐ No
I/We quit or refused or were fired from a job or job training in the last 30 days. ☐ Yes ☐ No

If you answered Yes to any of the above, complete the following:

NAME	Name and Address of Employer/Training Program	Last Day of Job/Training (Mo/Day/Yr)	Amount of Last Pay	Hours of work/ training in last 30 days	REASON FOR LEAVING OR REFUSAL
			$	Hours	
			$	Hours	
			$	Hours	

F. **In order to be available for employment do you and/or other members of the family 16 or older need help with the care of a child or other persons in your household?** ☐ Yes ☐ No

(14) COMPLETE THE FOLLOWING FOR THE CHILD'S FATHER WHO IS UNEMPLOYED AND LIVING IN THE HOME: If none, check (✓) ☐

Received, or was eligible to receive unemployment insurance benefits within the last 12 months. ☐ Yes ☐ No

Earned at least $50 or attended 5 days or more of work training in any quarter within the last 20 quarters. If Yes, complete the following by entering the year and checking (✓) the appropriate quarters below. ☐ Yes ☐ No

YEAR																				
QUARTER	JAN MAR	APR JUN	JUL SEP	OCT DEC	JAN MAR	APR JUN	JUL SEP	OCT DEC	JAN MAR	APR JUN	JUL SEP	OCT DEC	JAN MAR	APR JUN	JUL SEP	OCT DEC	JAN MAR	APR JUN	JUL SEP	OCT DEC
Work																				
Work Training																				

(15) I/WE HAVE ONE OR MORE ASSETS. ☐ Yes ☐ No
If Yes, complete the following and give the value of each asset. Assets include *cash, savings, money in checking accounts, stocks or bonds, notes, mortgages, deeds of trust, sales contracts, estates, trust funds, life or burial insurance, etc.*

ASSETS	APPLICANT	SPOUSE	OTHER HOUSEHOLD MEMBERS		
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

(16) I/WE OWN OR USE ONE OR MORE MOTOR VEHICLES (car, truck, motorbike) ☐ Yes ☐ No
If Yes, complete the following:

	1	2	3
Name of owner/user *(if you don't own, check use only box)*	☐ USE ONLY	☐ USE ONLY	☐ USE ONLY
Vehicle License Number and State of Registration			
Amount of last license fee paid	$	$	$
Year, make and model			
Monthly payment	$	$	$
Balance owed	$	$	$
Finance Company — Name			
Finance Company — Address			
Used for employment or training rehabilitation for employment	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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PERSONAL/REAL PROPERTY

(17) I/WE OWN OR USE PERSONAL PROPERTY ITEMS WHICH COST US AT LEAST $100 EACH OR ARE NOW WORTH AT LEAST $100 EACH (including gifts). If Yes, complete the following. ☐ Yes ☐ No

Include such things as household items (stove, refrigerator, freezer, clothes dryer, washer, dishwasher, air conditioner, appliances, t.v., stereo, phonograph, tape recorder, gardening and cleaning equipment, etc.); household furnishings (beds, chests, cabinets, couches, tables, chairs, desks, paintings, drapes, lamps, rugs, mirrors, etc.); employment/rehabilitation items (inventory, tools, machines, etc.); other personal property (livestock or fowl, jewelry, boats, campers, trailers, musical instruments, power tools, etc.).

Do not list wedding or engagement rings, heirlooms, clothing, or items that are rented or built-in as part of the house.

PERSONAL PROPERTY ITEM	IF A GIFT Check (✓)	PURCHASE PRICE	PURCHASE DATE	AMOUNT OWED	FOR COUNTY USE ONLY: HOUSEHOLD ITEMS	HOUSEHOLD FURNISH-INGS	EMPLOY./ REHAB. ITEMS	OTHER PERSONAL PROPERTY
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								
16.								
17.								
18.								
					TOTAL	TOTAL	TOTAL	TOTAL

(18) I/WE OWN OR ARE BUYING REAL (ESTATE) PROPERTY. ☐ Yes ☐ No
List all land and buildings that you own, have title to or share title on.

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TYPE (Land, home, apartment, etc.)		
USE (Home, income, investment)		
ADDRESS OR LOCATION		
OWNER(S)		
MORTGAGE COMPANY		
AMOUNT OWED		

(19) I/WE HAVE SOLD OR DISPOSED OF PROPERTY IN THE PAST 2 YEARS. ☐ Yes ☐ No
Check Yes if you have sold, transferred or given away any real estate or property (cash assets, trust funds, household and personal items, motor vehicles, boats, insurance policies, etc.)

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(20) I/WE HAVE ONE OR MORE SPECIAL NEEDS. ☐ Yes ☐ No

If Yes, complete the following:

SPECIAL NEED	NAME	AMOUNT PER MONTH
Transportation to treatment not available in the community		$
Special laundry service		$
Housework (unavailable from other household persons)		$
Special telephone equipment (hearing problem)		$
Excessive use of one or more utilities		$
(MEDICAL CONDITION AND DOCTOR'S NAME) Therapeutic diet		$

(21) I/WE NEED TO REPLACE ESSENTIAL HOUSEHOLD ITEMS, LOST OR DAMAGED DUE TO UNUSUAL CIRCUMSTANCES, WHICH CANNOT BE REPLACED FROM ANY SOURCE WITHOUT COST TO ME. ☐ Yes ☐ No

If Yes, explain below (include date, place and circumstances resulting in loss). List items such as clothing bedding, dishes and kitchen utensils, cook stove, refrigerator, space heater, double bed, etc., and give the value of each.

(22) SOCIAL SERVICES

A. I/We want information about a free medical examination for children living in my home. ☐ Yes ☐ No
The children, up to the age of 21, are entitled to free periodic medical exams, dental checks, eye and hearing tests, blood tests and immunizations. Follow-up medical treatment will be provided if necessary. Your doctor or the local health department may provide these services to your family.

B. I/We want information about free family planning services. ☐ Yes ☐ No
You are eligible for this service which can help you prevent unwanted pregnancy or to have children ONLY when you want them.

C. I/We want to talk to a social worker about other available services or about arranging **for transportation to obtain the above services.** ☐ Yes ☐ No

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CERTIFICATION

I have received and read a copy of the instructions for completing Form WR 2 and I understand that I am required to notify my eligibility worker at once if there are any changes in my (and members of my household living with me) source and amount of income, real property holdings, personal possessions or expenses, the number of persons in my household (including unrelated adults) living with me, or any change of address, employment or training status.

I understand that if I am dissatisfied with the decision of the county concerning my application for aid, I have a right to appeal to the Department of Benefit Payments, 744 P Street, Sacramento, California 95814.

I understand that the foregoing statements of fact provided by me on this form are subject to investigation and verification and my signature constitutes authorization for these investigations.

After answering all questions, you, and your spouse or other parent of the child(ren) living in the home, must sign the form. If you make a mark, a witness must also sign below. An interpreter or someone completing this form for you also must sign.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS OF FACT PROVIDED BY ME ON THIS FORM ARE TRUE AND CORRECT.

SIGNATURE (OR MARK)	DATE SIGNED	MAILING ADDRESS (NUMBER, STREET, CITY, ZIP)
SIGNATURE OF SPOUSE OR OTHER PARENT LIVING IN HOME	DATE SIGNED	HOME ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)
SIGNATURE OF WITNESS, INTERPRETER, OR PERSON COMPLETING FORM FOR RECIPIENT)	DATE SIGNED	

(23) DO ANY OF THE PERSONS LIVING IN THE HOME PAY FOR BOARD, ROOM OR BOTH? ☐ Yes ☐ No **If Yes, complete the following.**

FOR COUNTY USE ONLY

NAME (Last, First, Middle)	CHECK (✓) Room	Board	Both	AMOUNT PAID	HOW OFTEN Weekly	Monthly	Other

B. Does any member live in the home to provide nursing care, housekeeping services or care for children so that you or other members of the household can work? ☐ Yes ☐ No

If Yes, give this person's name:

C. Do any other persons live in the home? If so, give names and status – for example, do they share the home or rent? Do they live as a separate household unit? Explain fully:

D. Do you have a place to prepare cooked meals where you live? ☐ Yes ☐ No

E. Are you or your spouse unable to prepare meals because of health problems? ☐ Yes ☐ No

If Yes, do you receive meals from either:

1. Meals on Wheels Program – ☐ Yes ☐ No 2. A communal dining facility – ☐ Yes ☐ No

F. Are you, or any member of the household, a member of a drug addict or alcoholic rehabilitation treatment center? (If Yes, give name) _____ ☐ Yes ☐ No

Do you participate on a ☐ resident OR ☐ nonresident basis?

(24) EXPENSES

Give the following information about your household expenses.

LIST ONLY THOSE EXPENSES ACTUALLY BEING PAID. Expenses paid by another person or source are to be included.

	AMOUNT	HOW OFTEN ARE EXPENSES ACTUALLY PAID: Weekly	Every 2 Weeks	Twice Monthly	Monthly	NUMBER OF MONTHS TO BE PAID
1. SHELTER						
a. Rent or mortgage payment on home	$					
b. Utilities (if not included in rent)						
(1) Heating and cooking fuel (including wood)	$					
(2) Electricity	$					
(3) Telephone (basic charge for one)	$					
(4) Water	$					
(5) Sewage and/or garbage disposal fees	$					
c. Taxes and assessments (yearly payments)	$					
(1) Real estate taxes on home	$					
(2) Special assessments (if required by law)	$					
d. Home owner's fire insurance premium	$					
2. MEDICAL						
a. Physician and dental services	$					
b. Hospital or nursing care	$					
c. Health insurance and medicare	$					
d. Prescription drugs	$					
e. Transportation costs for medical care	$					
f. Other (specify)_____						
3. UNUSUAL						
a. Replacement or repair of property damaged or lost through vandalism, fire, theft, flood, storm, etc. (Explain on separate page, sign and date)	$					
b. Funeral expenses paid by a member of the household (Explain on separate page, sign and date)	$					
4. OTHER						
a. Payments for the care of a child or another person when necessary for a household member to work outside the home	$					
b. Tuition and mandatory fees for education (do not include cost of books or materials)	$					
(1) When paid?_____						
(2) For whom paid?_____						
(3) To whom paid?_____						
(4) Period covered by payments: From_____ To_____						
c. Court-ordered support/alimony payments	$					

5. Does someone who is not a member of the household pay for any of these or other expenses? ☐ Yes ☐ No
If Yes, give the following information:

NAME OF PERSON (Last, First, Middle)	TYPE OF EXPENSE	AMOUNT PAID

FOR COUNTY USE ONLY

(25) **DO YOU EXPECT ANY CHANGE IN YOUR HOUSEHOLD CIRCUMSTANCES – income, resources, living arrangements, expenses or other circumstances – IN THE NEAR FUTURE?** ☐ Yes ☐ No
If Yes, explain in detail.

(26) **IF ELIGIBLE FOR FOOD STAMPS I WOULD LIKE TO PURCHASE (check one):**
☐ Twice a Month ☐ Once a Month

(27) **I/WE WOULD LIKE THE COST OF FOOD STAMPS WITHHELD FROM MY/OUR GRANT.** ☐ Yes ☐ No

CERTIFICATION

I certify that this application has been examined by me (or read to me) and that the information given is true and correct to the best of my knowledge and belief. I agree to provide the County Food Stamp Office information necessary to verify any statements given in this application and hereby give permission to obtain such verification. I will also cooperate fully with state and federal personnel in a quality control review.

I agree to inform the County Food Stamp Office within 10 days of changes in income and/or deductions whenever such changes reach a total of more than $25.00 per month within the period of eligibility or of any change in household composition or living arrangement, and of any change in any other information I have given since such changes may affect eligibility to purchase food coupons or the amount to be paid for them.

I understand that when I plan to move to another county or state it may be possible for me to transfer my food stamp eligibility with me PROVIDED that I report the move to this food stamp office prior to my departure and obtain a transfer document FNS-286.

NONDISCRIMINATION: This application will be considered without regard to race, color, religious creed, national origin, or political beliefs.

I understand that I have a right to a hearing if I am not satisfied with the action taken on my application by the food stamp office. I may discuss the action with the County Welfare Department. If I am not satisfied with this discussion, I may request a hearing by the Department of Benefit Payments. The request may be written or oral, and must state why I am not satisfied. The request must be received by the Office of the Chief Referee, DBP, 744 P Street, Sacramento, California 95814, within 90 days of the postmarked date of the Notice of Adverse Action with which I am dissatisfied. I may be entitled to have my food stamps continued if I request a fair hearing within 10 days of the postmarked date of the Notice of Adverse Action.

BEFORE YOU SIGN YOUR NAME GO BACK AND CHECK TO SEE THAT EACH ITEM THAT APPLIES TO YOUR HOUSEHOLD HAS BEEN ANSWERED ACCURATELY.

PENALTIES FOR FRAUD: The state and federal law provides penalties including a fine, imprisonment or both for persons found guilty of obtaining food stamps for which they are not eligible by making false statements; or

FAILING TO REPORT PROMPTLY any changes in their circumstances. If evidence indicates that such individuals have willfully violated the law, they will be referred to the proper law enforcement authority for investigation and possible prosecution.

ANYONE WHO AIDS another person to obtain food stamps fraudulently is subject to the same penalties.

SIGNATURE OF HEAD OF HOUSEHOLD	DATE
SIGNATURE (AUTHORIZED REPRESENTATIVE OR OTHER PERSON COMPLETING APPLICATION	DATE

If an Authorized Representative completes application attach written authorization of head of household or spouse.

IF SIGNED BY "X" SIGNATURE OF WITNESS	DATE
SIGNATURE OF ELIGIBILITY WORKER COMPLETING CERTIFICATION	DATE

If you would like to have someone else purchase your coupons for you, give his name and address.

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

REQUIRED FORM – NO SUBSTITUTE PERMITTED

DEPARTMENT OF BENEFIT PAYMENTS

STEPFATHER QUESTIONNAIRE – DECLARATION

Please Print in Ink.

CASE NAME	CASE NUMBER	DATE

As the natural or adoptive mother of one or more of the children for whom you are applying for or receiving AFDC, you are required to provide the following information regarding the nonadoptive stepfather living in the home to determine the actual availability of your interest in the community property, including the earnings of your husband.

1. **My husband and I live together.** If **No,** state reason (include military service, employment away from home, etc.) ☐ Yes ☐ No

2. **My husband's income is available to me to use.** If **No,** state reason. ☐ Yes ☐ No

3. **My husband claims his stepchildren as dependents for income tax purposes.** ☐ Yes ☐ No

4. **My husband and I file a joint income tax return.** ☐ Yes ☐ No

5. **My husband and I receive income, money or benefits monthly.** If **Yes,** complete the following: ☐ Yes ☐ No

A WHO RECEIVES INCOME, MONEY OR BENEFITS	SOURCE OF INCOME, MONEY OR BENEFITS	GROSS MONTHLY AMOUNT
		$
		$
		$
		$

B **My husband pays support for persons outside the home.** ☐ Yes ☐ No

If **Yes,** indicate the amount actually paid monthly. . . . . AMOUNT $

6. **All or a portion of my husband's income is:** *(Check appropriate boxes and indicate monthly amount.)*

CHECK (✓)	STEPFATHER'S INCOME IS:	AMOUNT	CHECK (✓)	STEPFATHER'S INCOME IS:	AMOUNT
	Deposited in a joint checking or savings account . .	$		All kept by my husband.	$
	Deposited in my husband's separate checking or savings account	$		Kept in cash for both of us to use	$
	Deposited in my separate checking or savings account	$		OTHER *(including allowance, incidentals, lump sum, etc.) EXPLAIN*	
	Turned over to me to use for our family expenses . .	$			$

7. **My husband and I have the following expenses which are regularly paid as follows:**

TYPE OF EXPENSE	HOW IS THE EXPENSE PAID? (Indicate check, cash, money order, etc., below)		INDICATE AMOUNT PAID	
	By You	By Husband	From Your Income	From Husband's Income
Food.			$	$
Housing			$	$
Clothing			$	$
Utilities			$	$
Transportation . . .			$	$
Other Expenses . . .			$	$

8. **My husband and I have credit cards or charge accounts which are actually available for my use.** ☐ Yes ☐ No

SOURCE OF CREDIT (Firm, Bank or Credit Card)	ACCOUNT NUMBER	IN WHOSE NAME(S) Check (✓)		MAXIMUM CREDIT AVAILABLE (Dollar Amounts)
		You	Husband	
				$
				$
				$
				$

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ON THIS FORM ARE TRUE AND CORRECT.

SIGNATURE (NATURAL OR ADOPTIVE MOTHER)	DATE SIGNED	PLACE SIGNED (COUNTY)

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

REQUIRED FORM — NO SUBSTITUTE PERMITTED

DEPARTMENT OF BENEFIT PAYMENTS

ELIGIBILITY DETERMINATION SUMMARY — AFDC

INSTRUCTIONS: *Form WR 2,* **Statement of Facts Supporting Eligibility for Assistance,** *must be fully completed and signed by applicant before eligibility can be determined. Do not use this form until Form WR 2 has been fully completed unless basis for a denial decision can be established on partial completion or Form WR 2 is not returned. EAS Manual and WR 2 item references are included in parenthesis.*

CASE NAME (LAST, FIRST, MI)	CASE NUMBER (COUNTY-AID-SERIAL-FBU)		CROSS REFERENCE CASE NUMBER
PAYEE NAME	DISTRICT	WORKER	☐ NEW APPLICATION ☐ REAPPLICATION ☐ RESTORATION ☐ REDETERMINATION
STATUS OF MAN IN THE HOME ☐ U ☐ INCAP ☐ UNMARRIED FATHER ☐ STEPFATHER ☐ UAM	EO 1234567 PL 123456	F/A	

ELIGIBILITY FACTORS	EVIDENCE
(List first names of children after appropriate deprivation *(Item 2)* ☐ Due to Relinquishment for Adoption ☐ Due to Deceased Parent _____ ☐ Due to Physical or Mental Incapacity of Parent _____ ☐ Due to Unemployed Parent _____ ☐ Due to Continued Absence of Parent _____ ○ Children not meeting deprivation requirements _____	
A. Age Requirement (EAS 42–100) *(Items 2 and 13)* ☐ Under 18 years (unmarried) _____ ☐ 18 through 20 years (unmarried and regularly attending school or a training program, or enrolled in an institution of higher education) _____ ○ None of the above _____	
B. Residence Requirement (EAS 42–400) (If some meet requirements and some do not, check both items and list name of those who do not quality.) *(Items 5 and 6)* ☐ Meets residence requirements _____ ○ Does not meet residence requirement _____	
C. Institutional Status (EAS 42–500) *(Item 2 or WR 2.1)* ☐ Family members eligible while in facility _____ ○ Family members ineligible while in facility _____	
D. Registration Requirement for Employment, Manpower Services and Training (EAS 41–407) (If some nonexempt applicant family members are registered and some are not, check both items and list names of those nonexempt members who are not registered) *(Item 13)* ☐ Nonexempt registered ○ Nonexempt not registered _____	
E. Financial Status (EAS 42–303) *(Items 11, 12 and 13)* ☐ Net nonexempt income is less than appropriate Basic Standard of Adequate Care ○ Net nonexempt income exceeds appropriate Basic Standard of Adequate Care	
F. Property (Chapter 42–200) *(Items 8 and 15 thru 19)* **Personal Property** ☐ $600 or less for cash, securities or evidence of indebtedness *(Item 15)* ☐ $1,600 or less for personal property not excluded by regulation *(Item 17)* **Real Property (Assessed Value Less Encumbrances)** ☐ $5,000 or less *(Item 18)* **Other Requirements** ☐ Utilization requirements met *(Item 18)* ☐ Transfers made in accordance with regulations *(Item 19)* ○ **AFDC member(s), with excess property (not affecting eligibility of others).** **Names and item numbers** _____ ○ **Fails to meet one or more of the above requirements applicable to the program involved.**	***SEE REVERSE***

G. Computation for personal Property Reserve *(Item F)*	TOTAL	GRAND TOTAL	EVIDENCE
1. Cash *(Item 15)*			
2. Nonexempt Motor Vehicles *(Item 16)*			
3. Nonexempt Household Items *(Item 17)*			
4. Value of Household Furnishings in excess of $1500 *(Item 17)*			
5. Value of Employment/Rehabilitation Items in excess of $200 *(Item 17)*			
6. Value of Other Personal Property *(Item 17)*			
7. Burial Arrangements *(Item 15)*			
8. Cash Currender Value of Insurance Policies *(Item 8)*			
9. Total G2 through G8			
Total Personal Property Reserves, G1 + G7 (may not exceed $1,600)			

H. Food Stamp Assistance Household Eligibility Factors (63–2000)

1 ☐ 09 ○ Meets definition of a Food Stamp Household (63–2101).

2 ☐ 19 ○ Meets definition of Assistance Household (63–2110.1).

3 ☐ 29 ○ Meets conditions for exclusion of nonhousehold members (63–2102).

4 ☐ 39 ○ Has cooking facilities for food preparation (63–2210). Except as provided in 63–2211.

5 ☐ 49 ○ No member of an applicant household is a resident or operator of a boarding home (63–2215) or resident of an institution (63–2216) except as provided in 63–2216.1)

6 ☐ 59 ○ All nonexempt able-bodied members of applicant household have registered for work at EDD (63–2221).

7 ☐ 69 ○ No member of the applicant household is involved in an unlawful strike except as provided in 63–2230.

PROGRAM ELIGIBILITY

PROGRAM

☐ AFDC–U
☐ AFDC–FG
☐ AFDC–BHI
☐ C/R
☐ Asst. F/S

Effective Date of Aid (cash grant) or continuing eligibility established (redetermination)

MO DAY YR

ELIGIBLE PERSONS (Cash Grant) Name	Person Number	INELIGIBLE PERSONS (Cash Grant) Name	Person Number

○ APPLICATION FOR CASH GRANT DENIED OR WITHDRAWN — **Denial Code**
Reason:

○ INELIGIBLE FOR FOOD STAMPS AS ASSISTANCE HOUSEHOLD — ☐ **DFA 377 Sent** ☐ **DFA 377.1 Sent**
Reason:

☐ OTHER ACTION TAKEN, i.e., REFERRED FOR SERVICES, MEDICALLY NEEDY ONLY, MEDICALLY INDIGENT, NONASSISTANCE FOOD STAMPS, ETC. Specify:

○ INELIGIBILITY ESTABLISHED — **Disc. Code**
Reason:

Effective Date MO DAY YR

ELIGIBILITY WORKER	DATE	SUPERVISOR	DATE